HEALTH EQUITY IMPROVEMENT

CONTINUOUS QUALITY IMPROVEMENT STANDARDS

Developed under guidance from the Practice Transformation Taskforce (PTTF) as part of the Connecticut State Innovation Model Initiative

Program Description and Objective:

Description: Equity gap quality improvement will provide a standardized processes for networks to use data to identify and address healthcare disparities.

Objective: Provide Advanced Networks and Federally Qualified Health Centers (FQHCs) with a set of data/analytic standards that will enable them to identify disparities in care on a routine basis, prioritize the opportunities for reducing the identified disparities, design and implement interventions, scale those interventions across networks, and evaluate the effectiveness of the intervention.

High-Level Process:

1. Analyze clinical performance and/or individual experience stratified by sub-populations
2. Identify and prioritize opportunities to reduce health care disparities
3. Implement at least one intervention to address the disparity
4. Evaluate the effectiveness of the intervention

1. Analyze clinical performance and/or individual experience stratified by sub-populations

- The network analyzes select clinical performance and individual experience measures stratified by race/ethnicity, language, and other demographic markers including sexual orientation and gender identity
    - This will require that the network at a minimum capture Office of Management and Budget (OMB) race/ethnicity categories and preferred language in their EMR
- The network identifies valid clinical and care experience performance measures to compare clinical performance between sub-populations
    - Initially networks will use performance metrics aligned with the CT SIM quality scorecard[1]
        - Additional metrics are quantifiable and address outcomes rather than process whenever possible.
        - Metrics should meet generally applicable principles of reliability, validity, sampling and statistical methods.
- The network establishes method of comparison between sub-populations
    - Clinical outcome and individual experience measure can be compared internally amongst the network population or compared to a benchmark[2]

[1] The CT SIM Quality Scorecard is still in process, but will likely include diabetes, hypertension and asthma clinical performance measures

[2] Networks not performing well against a national/regional benchmark may want to consider starting by comparing internally while networks with little disparity between in-network sub-populations may benefit from utilizing a benchmark.

- For the CCIP pilot intervention the proposed sub-populations are pre-defined as White, Black, and Latino to ensure that there are large enough sample sizes to make valid statistical inferences.
- The stratification by race/ethnicity should be informed by the demographics of the population served by the network

2. Identify and prioritize opportunities to reduce health care disparities

- The network documents and makes available to the technical assistance vendor the results of the opportunities identified through data analysis
- The network develops a process to prioritize opportunities. Prioritization considers:
    - Significance to individuals in the sub-population experiencing a disparity in care, which is evaluated through engaging members of the sub-population to prioritize opportunities

3. Implement at least one intervention to address the disparity[3]

- The network conducts a root cause analysis for the disparity identified for intervention and develop an intervention informed by this analysis
- The root cause analysis utilizes:
    - Relevant clinical data
    - Input from the focus sub-population for whom a disparity was identified
    - Input from the focus sub population solicited through various venues
- The network designs an intervention and describes how the intervention will meet the needs/barriers identified in the root cause analysis
- The network involves members of the sub-population who are experiencing the identified disparity to design the interventions
- The network includes a Community Health Worker as a component of their intervention[4]
    - Standards for incorporating a Community Health Worker into the network to be available to and integrated into the primary care practice to support individuals experiencing the identified disparity who would benefit from the additional support of a CHW [see: Health Care Disparity Focused Community Health Worker Standards]
- The network implements an intervention in at least five practices

4. Evaluate the effectiveness of the intervention

- The network demonstrates that the intervention is reducing the health care disparity identified by:

[3] The technical assistance vendor will be responsible for ensuring the networks are familiar with the science of improvement, change management, and performance measurement. The vendor will work with the providers to ensure that the interventions are tested for effectiveness with an accepted methodology (i.e..; PDSA) before implementing and scaling. The technical assistance vendor will work with the PMO and the providers to identify opportunities to aggregate and report data on the effectiveness of these interventions to promote the population health goals of Connecticut.

[4] Research has shown CHWs to effectively address healthcare disparities arising from cultural and language barriers to self-care management and education. Accordingly, it is expected that the CHW will only be one component of the intervention and is being recommended as a required intervention by CCIP.

    - Tracking aggregate clinical outcome and individual experience measures aligned with the measures used to establish that a disparity existed
    - Achieving improved performance on measures for which a disparity was identified
- Identify opportunities for quality and process improvement. This will require:
    - Defining process and outcome metrics for the interventions pursued
    - Establishes a method to share performance[5] regularly with relevant care team participants to collectively identify areas for improvement

[5] Performance is commonly shared through a dashboard or scorecard. Networks should also consider establishing learning collaboratives that bring together the different practices in their network to share best practices